State of California

OFFICE OF THE INSPECTOR GENERAL

MATTHEW L. CATE, INSPECTOR GENERAL

FOR IMMEDIATE RELEASE
December 12, 2006

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The California Institution for Men has worked to correct most of the problems surrounding an officer's 2005 stabbing death, but the Department of Corrections and Rehabilitation has made limited progress in correcting statewide deficiencies

The management of the California Institution for Men, where Correctional Officer Manuel A. Gonzalez, Jr. was stabbed to death in January 2005, has taken important steps to rectify conditions that may have contributed to the attack, the Inspector General said today. But Department of Corrections and Rehabilitation administrators have made limited progress in correcting related problems that fall under the department's jurisdiction.

"The leadership of the California Institution for Men is to be commended for its excellent response in correcting the problems that may have led to this tragedy," said Inspector General Matthew Cate.

"Now the Department of Corrections and Rehabilitation needs to demonstrate the same sense of urgency by correcting the statewide operational and security deficiencies that may have contributed to the incident," Cate said.

Following the Officer Gonzalez's death, the Inspector General performed an intensive review of the circumstances surrounding the incident and in March 2005 issued a report listing 42 recommendations needed to correct numerous safety and security deficiencies. Twenty of the 42

recommendations were directed toward the California Institution for Men, while the remaining 22 were directed at the department.

The March 2005 review revealed that among other problems, the institution had assigned the inmate ultimately charged with the attack to a general population cell even though he had a long history of violent behavior, and that at the time of the stabbing, the officers on duty, including the victim, had violated safety and security protocols. The Inspector General also found that prison managers had needlessly delayed distributing protective vests to the custody staff, storing them in a warehouse while they waited until they had enough vests for everyone designated to receive them.

The Inspector General also found from the March 2005 review that the medical clinic at the prison was poorly equipped and ill-prepared to handle the stabbing and that because of the department's ambiguous emergency protocols, the institution failed to implement emergency operations policies, causing confusion in the chain of command and destruction of the crime scene.

In a follow-up review released today, the Inspector General reported that the California Institution for Men has addressed all of its 20 recommendations, fully or substantially implementing 90 percent, but that the California Department of Corrections and Rehabilitation has implemented only 50 percent of the recommendations that fall under its responsibility.

The follow-up review found that among other changes, the California Institution for Men now requires that parolees with violent histories who return to custody be placed in administrative segregation until they can be further assessed and has made protective vests available to the custody staff.

In contrast, despite a plan that called for corrective actions to be completed several months ago, the Department of Corrections and Rehabilitation has yet to develop new emergency medical procedures to better prepare institutions for events such as the January 2005 stabbing; to revise the emergency operations plan affecting state prisons; or to clearly define responsibilities and procedures at prisons for securing crime scenes and processing evidence.

The full text of the Inspector General's follow-up review can be viewed and downloaded from the Office of the Inspector General's web site at http://www.oig.ca.gov/. To view the report, click on

the report title, "Follow-up Review of the Special Review into the Death of Correctional Officer Manuel A. Gonzalez, Jr. on January 10, 2005 at the California Institution for Men" (December 2006) on the home page or on the link to Bureau of Audits and Investigations, Special Reviews, under "California Institution for Men, Follow-up Review of the Special Review into the Death of Correctional Officer Manuel A. Gonzalez, Jr. on January 10, 2005 at the California Institution for Men" (December 2006).

The Office of the Inspector General is an independent state agency responsible for oversight of the California Department of Corrections and Rehabilitation. The office carries out its mission by conducting audits, special reviews, and investigations of the department to uncover criminal conduct, administrative wrongdoing, poor management practices, waste, fraud, and other abuses by staff, supervisors, and management. The special review was conducted under the authority provided to the Inspector General in California Penal Code section 6126.

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